

# Your summary of benefits

Anthem Blue Cross

County of San Luis Obispo

Your Plan: Modified EPO 0/15/0

Your Network: EPO

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>See notes section to understand how your deductible works.</i>	\$0 single / \$0 family	\$0
<b>Out-of-Pocket Limit</b> <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$1,500 single / \$3,000 family	No limit
<b>Preventive care/screening/immunization</b>	No charge	Not covered
<b>Doctor Home and Office Services</b>		
<b>Primary care visit to treat an injury or illness</b>	\$15 copay per visit	Not covered
<b>Specialist care visit</b>	\$15 copay per visit	Not covered
<b>Prenatal and Post-natal Care</b>	No charge	Not covered
<b>Other practitioner visits:</b>  Retail health clinic On-line Visit Chiropractor services <i>Coverage for In-Network Provider is limited to 20 visit limit per benefit period combined with Acupuncture visits.</i> Acupuncture <i>Coverage for In-Network Provider is limited to 20 visit limit per benefit period combined with Chiropractor visits</i>	\$15 copay per visit \$15 copay per visit \$15 copay per visit \$15 copay per visit	Not covered Not covered Not covered Not covered

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<b>Other services in an office:</b> Allergy testing Chemo/radiation therapy Hemodialysis Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i>	No charge \$15 copay per visit \$15 copay per visit No charge	Not covered Not covered Not covered Not covered
<b>Diagnostic Services</b> <b>Lab:</b> Office Freestanding Lab Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
<b>X-ray:</b> Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
<b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b> Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
<b>Emergency and Urgent Care</b> <b>Emergency room facility services</b> <i>This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.</i> <b>Emergency room doctor and other services</b>	\$50 copay per visit  No charge	Covered as In-Network  Covered as In-Network
<b>Ambulance (air and ground)</b>	No charge	Covered as In-Network

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<b>Urgent Care (office setting)</b>	\$15 copay per visit	Not covered
<b>Outpatient Mental/Behavioral Health and Substance Abuse</b>		
<b>Doctor office visit</b>	\$15 copay per visit	Not covered
<b>Facility visit:</b>		
Facility fees	No charge	Not covered
<b>Outpatient Surgery</b>		
<b>Facility fees:</b>		
Hospital	No charge	Not covered
Freestanding Surgical Center	No charge	Not covered
<b>Doctor and other services</b>	No charge	Not covered
<b>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</b>		
Facility fees (for example, room & board)	No charge	Not covered
Doctor and other services	No charge	Not covered
<b>Recovery &amp; Rehabilitation</b>		
Home health care	No charge	Not covered
<b>Rehabilitation services (for example, physical/speech/occupational therapy):</b>		
Office <i>Costs may vary by site of service.</i>	\$15 copay per visit	Not covered
Outpatient hospital	\$15 copay per visit	Not covered
Habilitation services	\$15 copay per visit	Not covered
<b>Cardiac rehabilitation</b>		
Office	\$15 copay per visit	Not covered
Outpatient hospital	\$15 copay per visit	Not covered

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<b>Skilled nursing care (in a facility)</b> <i>Coverage for In-Network Provider is limited to 100 day limit per benefit period.</i>	No charge	Not covered
<b>Hospice</b>	No charge	Not covered
<b>Durable Medical Equipment</b>	No charge	Not covered
<b>Prosthetic Devices</b>	No charge	Not covered

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## Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copay and coinsurance.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to [https://le.anthem.com/pdf?x=CA\\_LG\\_EPO](https://le.anthem.com/pdf?x=CA_LG_EPO). This custom plan may contain exclusions and limitations that are not listed there. Please consult your EOC for a complete list of exclusions and limitations.
- For additional information on this plan, please visit [sbc.anthem.com](http://sbc.anthem.com) to obtain a Summary of Benefit Coverage.